STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., GOVERNOR

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

December 17, 1979

ALL-COUNTY LETTER NO. 79-81 (IHSS)

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: IMPLEMENTATION OF AB 1940; ORDER/CONSENT FORM (IHSS)

REFERENCE:

The regulations implementing AB 1940, which authorizes the provision of paramedical services through IHSS, were recently filed on an emergency basis and are now in effect. MPP 30-457.96 requires the use of a form developed or approved by the State Department of Social Services when securing an order by a licensed health care professional and a signed statement of informed consent by the recipient. The attached form (SOC 321) has been developed for use by the counties to satisfy the regulatory requirements. An initial supply of this form will be mailed to you within the next two weeks. In the interim, in order to implement the new regulations immediately, counties may duplicate the attached form as needed.

Additional supplies of the SOC 321 may be ordered through the standard ordering procedure at the following address:

Department of Social Services Warehouse
6150 27th Street
Sacramento, CA 95822
Telephone: (916) 322-6250

The regulations provide for the use of county versions of the consent/order form subject to prior approval by the department. In the absence of such approval, counties are required to use form SOC 321.

JAMES H. GOMEZ
Deputy Director

Attachment

cc: CWDA

Contact Reference: Program Management Consultant
Adult Services Operations Bureau
744 P Street, M/S 5-100
Sacramento, CA 95814
Telephone: (916) 445-8724

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR ORDER AND CONSENT — PARAMEDICAL SERVICES

PATIENT'S NAME
MEDI-CAL IDENTIFICATION NUMBER

TO:

Dear Doctor:

This patient has applied for In-Home Supportive Services (IHSS) and stated that he/she needs certain paramedical services in order for him/her to remain at home. You are asked to indicate on this form what specific services are needed and what specific condition necessitates the services.

In-Home Supportive Services is authorized to fund the provision of paramedical services, if you order them for this patient. For the purposes of this program, paramedical services are activities which, due to the recipient's physical or mental condition, are necessary to maintain the recipient's health and which the recipient would perform for himself/herself were he/she not functionally impaired. These services will be provided by In-Home Supportive Services providers who are not licensed to practice a health care profession and will rarely be trained in the provision of health care services. Should you order services, you will be responsible for directing the provision of the paramedical services.

Your examination of this patient is reimbursable through Medi-Cal as an office visit.

If you have any questions, please contact me.

SIGNED	TITLE	TELEPHONE NUMBER	DATE

TO BE COMPLETED BY LICENSED PROFESSIONAL:

NAME OF LICENSED PROFESSIONAL	OFFICE TELEPHONE

OFFICE ADDRESS (IF NOT LISTED ABOVE)

TYPE OF PRACTICE

- ☐ Physican/Surgeon
- ☐ Podiatrist
- ☐ Chiropractor
- ☐ Dentist

CONTINUED ON BACK

RETURN TO: (County Welfare Department)

Does the patient have a medical conc on which results in a need for IHSS param al services?:

☐ YES ☐ NO If YES, list the condition(s) below:

List the paramedical services which are needed and should be provided by IHSS in your professional judgement.

TYPE OF SERVICE	TIME REQUIRED TO PERFORM THE SERVICE EACH TIME PERFORMED	FREQUENCY *		HOW LONG SHOULD THIS SERVICE BE PROVIDED?
		# OF TIMES	TIME PERIOD	

* Indicate the number of times a service should be provided for a specific time period: (Example: two times daily, etc.)

Additional comments:

☐ IF CONTINUED ON ANOTHER SHEET, CHECK HERE

CERTIFICATION

I certify that I am licensed to practice in the State of California as specified above and that this order falls within the scope of my practice. In my judgement the services which I have ordered are necessary to maintain the recipient's health and could be performed by the recipient for himself/herself were he/she not functionally impaired.

I shall provide such direction as is needed, in my judgement, in the provision of the ordered services.

I have informed the recipient of the risks associated with the provision of the ordered services by his/her IHSS provider.

SIGNATURE ▶ | DATE

PATIENT'S INFORMED CONSENT

I have been advised of risks associated with provision of the services listed above and consent to provision of these services by my In-Home Supportive Services provider.

SIGNATURE ▶ | DATE